State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Enclosed is the Medi-Cal provider enrollment application package you requested. Requests for additional application packages should be directed to EDS, the Medi-Cal fiscal intermediary, at 1-800-541-5555.

PLEASE NOTE: New regulations (effective February 2003) governing the enrollment of providers in the Medi-Cal program now require additional information to be submitted with the application package. Applications will be reviewed to ensure that applicants and providers meet the new criteria, including the verification of insurance.

Instructions for completion of these documents are included on the forms. Please read the instructions carefully. If after reading the instructions you have questions regarding the completion of the application, disclosure statement and/or provider agreement, you may call the Provider Enrollment Branch at (916) 323-1945 between the hours of 8 a.m. and 5 p.m. to leave a message. Each applicant is sent written notice when the application package is received. Due to the volume of applications received, program staff is unable to reply to a request for the status of applications in process. Therefore, please allow for the 120 days stipulated in regulations for processing your application prior to contacting the Department regarding the status of your application. Application packages that are incomplete or are submitted on a form other than the current Department of Health Services (DHS)-issued forms will be returned to you.

It is your responsibility to report to DHS any changes to information previously reported on the enrollment documents within 35 days of the change. Most changes may be reported on a *Medi-Cal Supplemental Application*. You may request a *Medi-Cal Supplemental Application* by contacting EDS.

For more information on the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at **www.medi-cal.ca.gov** and click on "Publications," then "Provider Enrollment."

If you have any questions, please the call Provider Enrollment Branch at (916) 323-1945.

Provider Enrollment Branch
Payment Systems Division

Enclosures

(Revised 2/03)

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www.consumerenergycenter.org/flex/index.html

INSTRUCTIONS FOR COMPLETION OF MEDI-CAL PHYSICIAN APPLICATION/AGREEMENT

DO NOT USE correction tape, white out, etc.; highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers may also need to provide additional information and documentation. Applicants may be subject to an on-site inspection prior to enrollment. Applicants or providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to the application, the attached disclosure statement must also be completed for enrollment or continued enrollment.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations, Section 51000.50.

Enrollment action requested (check all that apply); enter the date you are completing the application.

“New provider” means the applicant is not currently enrolled in the Medi-Cal program and would like to have a Medi-Cal provider number issued.

“Additional business address” means the applicant is currently enrolled in the Medi-Cal program and is requesting a new provider number be issued for an additional business location.

“Add rendering provider” means to add a rendering provider to a provider group applicant or an existing provider group. If this is a request to be added as a rendering provider to a provider group applicant, enter the provider group name. If this is a request to be added as a rendering provider to an existing provider group, enter that provider group provider number.

“Delete as a rendering provider in a provider group” means you no longer wish to be enrolled as a rendering provider in a provider group. Specify the provider group number. If you are deleting from a provider group and wish to enroll in the Medi-Cal program as an individual provider, also check the “New provider” box and complete the entire application with information specific to your individual practice.

“Continued Enrollment” means the provider is currently enrolled in the Medi-Cal program and would like to continue participation. Enter the provider number that you would like to continue to use. (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Regulations Section 51000.55.)

“Reactivate provider number” means you want to re-establish yourself as a Medi-Cal provider.

“Type of Entity”: Check ***one box only*** which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, please attach a legible copy of the partnership agreement.

1. “Legal name” means the name listed with the Internal Revenue Service (IRS).
2. “Business name” means the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Name Permit number and effective date. Attach a legible copy of the Fictitious Name Permit to the application.
3. “Business telephone number” means the primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall ***not*** be used as the primary business telephone.
4. “Business address” means the actual business location where services are rendered, including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
5. “Pay to address” means the address to which the applicant or provider wishes to receive payment. The “pay to” address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. “Mailing address” is where the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. Enter the medical license number(s) of the applicant or provider. Attach a legible copy of the license. List the specialty(ies) and indicate if board certified or eligible.
8. Enter the Medicare billing number.
9. Enter the Federal Employer Identification Number (FEIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or Form 2363.

10. If the business is a sole proprietorship not using a FEIN, provide the social security number or Individual Taxpayer Identification Number (ITIN) of the sole proprietor. Attach a legible copy of the ITIN verification, if applicable.
11. Enter the Clinical Laboratory Improvement Amendment (CLIA) certificate number. Attach a legible copy of the CLIA certificate. The name and address on the certificate must match the name and address as entered in numbers 1 and 4.
12. Provide the State Laboratory License/Registration number. Attach a legible copy of the license/registration to the application. If this does not apply to you, enter "N/A."
13. Provide the driver's license or state-issued identification number and state of issuance of the individual named in number 1. Attach a legible copy to the application.
14. List the date of birth of the individual named in number 1.
15. List the gender of the individual named in number 1.
16. Enter any local business license or permit numbers for any city or county or city and county where you conduct your business activities and attach copies to the application. If this does not apply to you, enter "N/A."
17. Enter the Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit. If this does not apply to you, enter "N/A."
18. Provide the requested information. Attach a legible copy(ies) of applicant's current Certificate of Insurance for Comprehensive Liability Insurance to this application.
19. Provide the requested information. Attach a legible copy(s) of applicant's current Certificate of Insurance for Professional Liability Insurance to this application.
20. Provide the following information:
    - Whether the applicant or provider has hospital privileges.
    - If not, please explain why (if arrangements have been made with another physician for admitting patients, please provide his/her name, address, and telephone number).
    - The name(s), address(es), and telephone number(s) of the hospital(s) where current privileges have been granted.

    Attach additional sheet if needed.
21. If you are providing services in a hospital or clinic (facility), please complete this certification.
22. Print name of the physician signing the application. An original signature of the individual is required. Include the city, state, and the date where and when the application was signed.

✓ **REMEMBER TO ATTACH A LEGIBLE COPY OF THE FOLLOWING, IF APPLICABLE:**

❒ Driver's license or state-issued identification card

❒ FEIN or ITIN verification

❒ CLIA Certificate

❒ Medical license(s)

❒ Fictitious Name Permit

❒ State Laboratory License/Registration

❒ Disclosure Statement (DHS 6207)

❒ Certificate(s) of Insurance for Liability and Professional Liability Insurance

❒ Local business license(s) or permit(s)

❒ Seller's Permit

MEDI-CAL PHYSICIAN APPLICATION/AGREEMENT

FOR STATE USE ONLY

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: Department of Health Services
  Provider Master File Unit
  P.O. Box 942732
  Sacramento, CA 94234-7320
  (916) 323-1945

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check all that apply):

Date

- ❒ New provider
- ❒ Additional business address—current Medi-Cal provider number:_____
- ❒ Add rendering provider to:
  - ❒ Provider group applicant—group name: _____
  - ❒ Existing provider group—specify group provider number(s):_____
- ❒ Delete as a rendering provider in a provider group—specify group provider number(s): _____
- ❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, California Code of Regulations, Section 51000.55.) Current Medi-Cal provider number:_____
- ❒ Reactivate provider number—Medi-Cal provider number: _____

Type of entity (check one):

- ❒ Sole proprietor (unincorporated)
- ❒ Partnership
- ❒ Government
- ❒ Corporation:
  Corporate number: _____
  State incorporated: _____
- ❒ Limited liability corporation:
  Corporate number: _____
  State incorporated: _____
- ❒ Other: _____

1. Legal name of applicant or provider (as listed with the IRS) (last) (first) (middle)

2. Business name, if different

3. Business telephone number
( )

Is this a fictitious business name? ❒ Yes ❒ No

If yes, list the Fictitious Name Permit number

Effective date

(Attach a legible copy of the Fictitious Name Permit issued by the Medical Board.)

4. Business address of location where services are rendered (number, street)	City	County	State	Nine-digit ZIP code
5. "Pay to" address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code
6. Mailing address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code

7. Medical license number (attach a legible copy)

List specialty(ies)

	YES	NO
Board certified	❒	❒
Board eligible	❒	❒

8. Medicare billing number

9. Federal Employer Identification Number (FEIN) (Attach a legible copy of the IRS form.)

____ ____ — ____ ____ ____ ____ ____ ____ ____

10. Social security number or Individual Taxpayer Identification Number (ITIN) (If Sole Proprietor not using a FEIN, you must disclose this number and attach a legible copy of the ITIN verification, if applicable.) (See Privacy Statement on page 5.)

____ ____ ____ — ____ ____ — ____ ____ ____ ____

11. Clinical Laboratory Improvement Amendment (CLIA) certificate number (attach a legible copy)

12. State Laboratory License/Registration number (attach a legible copy)

13. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

14. Date of birth

15. Gender
❒ Male ❒ Female

16. Any local business license numbers/permits (attach legible copies)

17. Seller's Permit number (attach a legible copy)

18. **Proof of Liability Insurance**—Applicant must attach a copy of their certificate of insurance to this application.

Name of insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)

Insurance agent's name—(first) (middle) (last) (Jr., Sr., etc.)

Telephone number	Fax number	E-mail address
( )	( )	

19. **Proof of Professional Liability Insurance**—Applicant must attach a copy of their certificate of insurance to this application.

Name of insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)

Insurance agent's name—(first) (middle) (last) (Jr., Sr., etc.)

Telephone number	Fax number	E-mail address
( )	( )	

20. **Hospital Privileges**

Do you have current hospital privileges? ❒ Yes ❒ No

If no, please explain: _____

If yes, please provide the following (attach additional sheet if needed):

Name of hospital		Telephone number ( )	
Address (number, street)	City	State	ZIP code

If you are applying as a rendering provider to a group, please disregard this question.

21. **Self certification and statement of intent to employ a separate billing method for hospital/clinic-based physician.** ***(To be completed only if the practice location is a licensed facility.)***

The undersigned hospital/clinic and physician agree to the following requirement for the issuance of a Medi-Cal provider number to the hospital/clinic-based physician. It is agreed and understood by _____ and
(Physician Name)
_____ that there shall be no duplicate
(Hospital/Clinic Name)
billing for inpatient services rendered to Medi-Cal beneficiaries. All billing for inpatient services provided by the physician to Medi-Cal beneficiaries shall be billed using the physician's provider number. To ensure the money paid to the physician is not included in the cost settlement process, we recommend that the hospital/clinic set up a separate nonreimbursable cost center to account for all clinic-related payments. Additionally, the hospital/clinic should keep track of overhead support costs related to the reimbursable costs. At year end the costs related to the guarantee to the physician's clinical billings should be easily identifiable by our audit staff on your cost report. If it appears impossible/impractical for you to set up a separate cost center, then the direct cost related to physician clinical activities at a minimum should be eliminated from the trial balance cost via an A-8 adjustment on your cost report. This method of billing will become effective for services performed on or after _____. We declare under penalty of perjury
(Date)
under the laws of the State of California that the foregoing information is true and correct to the best of our knowledge.

Hospital/clinic name

Address (number, street)	City	State	ZIP code

Print name of authorized hospital/clinic representative	Authorized hospital/clinic representative signature	Date

Print physician name	Business name

Physician signature	Date

22. **I declare under penalty of perjury under the laws of the State of California that the foregoing information and all attachments are true, accurate, and complete to the best of my knowledge and belief. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information within 35 days to the Department of Health Services, Provider Enrollment Branch. I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual. I understand that it is my responsibility to read the manual and its updates.**

Printed name of physician (last) (first) (middle)

Signature of the physician

Executed at: _____, _____ on _____
(City) (State) (Date)

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Health Care Financing Administration, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, 714 P Street, Room 950, Sacramento, CA, 95814, (916) 323-1945.